# Featured Correspondence

## Alternative treatments for angina

**To the Editor:** In his editorial on ''Alternative treatments for angina'',[1] Dr Lanza makes no mention of the value of rehabilitation, especially patient and carer education, in improving quality of life. Given the central role of patient education in (refractory) angina management, this requires comment.

Damaging misconceptions are common in people with angina and their carers, and education is a potent and critically important intervention that may have profound effects on understanding, behaviour and quality of life.[2 3] It is for this reason that both the ESC and the AHA/ACC/ACIP/ASM stable angina management guidelines recommend a continuous process of identifying and clarifying misconceptions throughout care.[4 5] Similarly, the ESC Refractory Angina Study Group came to the same conclusion for the same reason.[6] It is perhaps because rehabilitation and patient education are not regarded as ''treatment'' that this most important aspect of good clinical care is so often neglected.

It is of great concern that this oversight seems to characterise each point of the patient's journey. The ACC/AHA guidance has observed that, ''…healthcare providers tend to focus on diagnostic and therapeutic interventions, often overlooking critically important aspects of high-quality care. Chief among these neglected areas is the education of patients.''[5]

This point was vividly illustrated in an editorial on the British Cardiac Intervention Society website in 2001, where it was observed that, ''The under-provision of cardiologists, outpatient facilities, hospital beds, cardiac catheterisation laboratories, and importantly, IT personnel and hardware in the average UK intervention centre frequently results in the patient arriving on the day of the procedure, having never been seen previously, and in many cases, not having met the interventional cardiologist before arriving in the catheterisation laboratory.''[7]

It may be that clinicians do not put much store by clinical guidelines, however authoritative, but what is intriguing about this failure to educate patients is that it is not simply a minor clinical governance issue. Education is a decisive intervention for patients with angina and has the force of law. The requirement to ensure that patients are fully informed has been a necessary element of valid consent for decades, but as recently as 2001, the BMA Consent Working Party was able to conclude that ''current awareness of the relevant ethical and legal principles relating to consent among the medical profession is largely inadequate''.[8] To clarify the guidance on consent, the parliamentary ombudsman and the president of the Society of Cardiac Surgeons produced a joint recommendation on consent practice, which emphasises the need to ensure full disclosure of facts.[9] The joint statement reflects the trend away from the notion that doctors can decide what it is necessary for the patient to know, towards the North American standard of disclosing what a ''prudent patient'' would wish to take into account in making a decision about treatment. More recently the GMC's update of ''Good Medical Practice'' makes explicit the requirement to ensure that patients fully understand their condition to enable them to be full and active participants in the decision-making process.[10]

In our experience many of the problems encountered by patients with refractory angina and their carers are iatrogenic, arising from a deficient ''education'' process, often involving many different healthcare professionals over many years. The perceived referral criterion for specialist refractory angina management is when no further intervention is possible, and this point in the patient's career marks a significant moment when patients' views about their condition can be adversely influenced by poorly communicated information.

We often meet patients who, having been told that further revascularisation is not feasible, erroneously believe that their lives are threatened by their stable angina. The way in which this message is delivered to patients often involves such colourful phrases as ''I am sorry but your narrowings are just too far gone and there is nothing more that can be done''; ''he's a walking time bomb''; ''you must take things very easy''; ''the artery is hanging by a thread''.

Much of our work involves treating the damaging consequences of cardiac misconceptions with individually targeted education. Careful dissection of the beliefs and misconceptions of patients with angina about their condition is rewarding for health professionals and benefits patients by improving their quality of life, by lowering the frequency and duration of hospital admissions and by reducing the frequency and severity of pain. The alternative to patient education is the risk for doctors that they may be open to challenge for having specified treatment for patients who have given consent on the basis of fundamental misconceptions about the nature of their condition.

**Michael R Chester, John D Bridson**
National Refractory Angina Centre, RLBUHT, Liverpool, UK

Correspondence to: Dr M R Chester, National Refractory Angina Centre, RLBUHT, Liverpool, L14 3PE, UK; chester@angina.org

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### References

1 **Lanza GA**. Alternative treatments for angina. *Heart* 2007;**93**:544–6.
2 **Moore RK**, Groves D, Bateson S, *et al*. Health related quality of life of patients with refractory angina before and one year after enrolment onto a refractory angina program. *Eur J Pain* 2005;**9**:305–10.
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7 **British Cardiovascular Intervention Society**. *Informed consent*. http://www.bcis.org.uk/news/News1588 (accessed 20 May 2007).
8 **British Medical Association**. *Report of the Consent Working Party*. http://www.bma.org.uk/ap.nsf/Content/Reportoftheconsentworkingparty (accessed 20 May 2007).
9 **Parliamentary and Health Service Ombudsman, and the President of the Society of Cardiothoracic Surgeons of Great Britain and Ireland a joint report**. *Consent in cardiac surgery: a good practice guide to agreeing and recording consent*, May 2005. http://www.ombudsman.org.uk/improving_services/best_practice/cardiac05/index.html (accessed 20 May 2007).
10 **General Medical Council**. http://www.gmc-uk.org (accessed 20 May 2007).

**The author's reply:** Dr Chester and Dr Bridson regret that in my editorial on treatment options for refractory angina[1] I did not mention patient education and rehabilitative programmes.

I fully agree with their observation that optimal patient–physician interaction and patient education about his/her coronary disease are crucial points in the treatment of angina symptoms. However, this, together with optimal drug treatment and correction of any condition favouring angina recurrence, should be part of the basic approach to patients with angina unsuitable for coronary revascularisation (as it should be for every patient with any kind of disease), rather than being considered as a specific form of treatment for patients with refractory angina.[2] In fact, in patients who are not revascularisable, refractory angina should be diagnosed only when an appropriate global medical approach (including patient's education) fails to control symptoms adequately.

As far as the role of rehabilitation is concerned, I also agree that exercise programmes and training are potentially helpful for improving ischaemic threshold and symptoms in patients with refractory angina. However, it should be recognised that, at present, there are no published data supporting the use of rehabilitation in this specific group of patients. In the studies by the Chester and Bridson group, a significant improvement of angina status and quality of life is reported applying a global supportive approach, including cardiac rehabilitation together with outpatient counselling and cognitive behavioural therapy.[3 4] However, most patients also received specific forms of treatment for refractory angina, mainly transcutaneous electrical nerve stimulation and temporary sympathectomy,[3 4] thus making difficult to know the role of rehabilitation in clinical improvement. In fact, the high proportion of patients needing alternative forms of treatment in their population suggests that rehabilitative programmes might be insufficient to achieve satisfactory results in most cases. Thus an appropriately designed study is required to establish whether rehabilitation can be considered a valid treatment option for patients with refractory angina.

**Gaetano A Lanza**

Correspondence to: Dr G A Lanza, Istituto di Cardiologia, Università Cattolica del Sacro Cuore, L.go A. Gemelli, 8, Roma 00156, Italy; g.a.lanza@inwind.it

Competing interests: None declared.

## References

1 **Lanza GA**. Alternative treatments for angina. *Heart* 2007;**93**:544–6.
2 **Mannheimer C**, Camici P, Chester MR, *et al*. The problem of chronic refractory angina Report from the ESC Joint Study Group on the Treatment of Refractory Angina. *Eur Heart J* 2002;**23**:355–70.
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## CORRECTION

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McMahon CJ, Pignatelli RH, Nagueh SF, Lee VV, Vaughn W, Valdes SO, Kovalchin JP, Jefferies JL, Dreyer WJ, Denfield SW, Clunie S, Towbin JA, Eidem BW. Left ventricular non-compaction cardiomyopathy in children: characterisation of clinical status using tissue Doppler-derived indices of left ventricular diastolic relaxation. *Heart* 2007;93:676–81.

The journal apologises for an error in an author name in this paper. On page 676 in the author list and on page 681 in the author affiliations ''J Lynn Jefferies'' should be **John L Jefferies**.

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# IMAGES IN CARDIOLOGY

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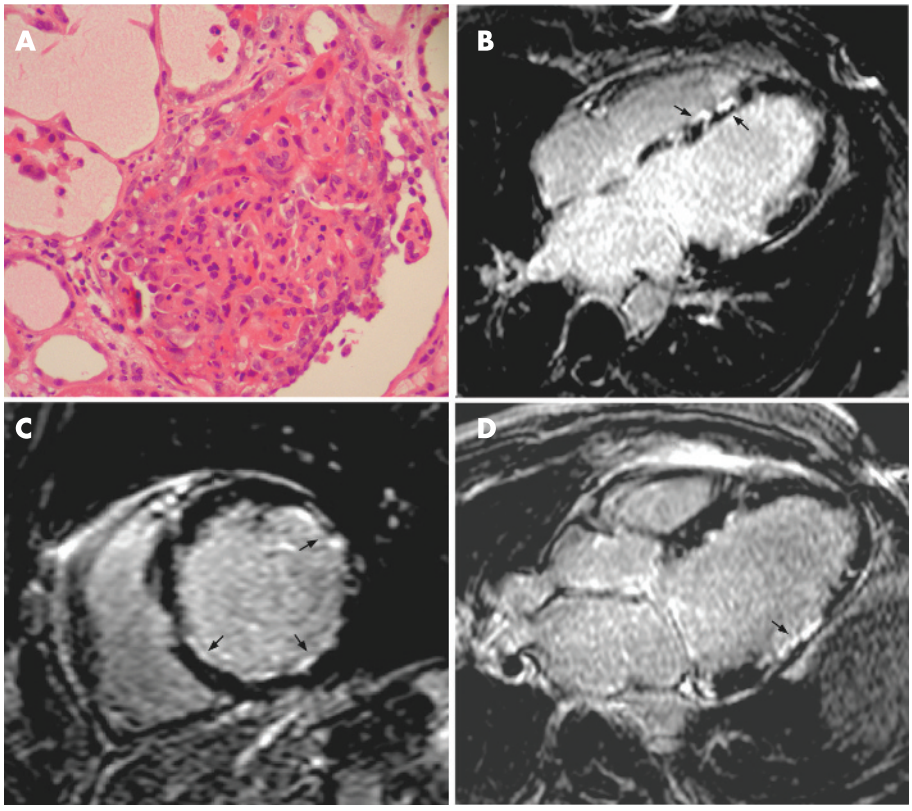
## Cardiomyopathy associated with Wegener's granulomatosis

A 35-year-old man with no history of cardiovascular disease presented with severe biventricular heart failure, after a 6-week history of fever, rigor, weight loss and unresolving gingivitis. An electrocardiogram showed sinus tachycardia with T-wave flattening, and chest *x* ray examination confirmed congestive heart failure and cardiomegaly. Serum troponin I was raised at 20.1 µg/l, and transthoracic echocardiography showed a severely dilated cardiomyopathy with a left ventricular ejection fraction (EF) of 10%. Concurrently, he developed rapidly progressive renal failure (peak creatinine 500 µmol/l) with microscopic haematuria and severe proteinuria. Renal biopsy demonstrated a pauci-immune glomerulonephritis (panel A). The presence of a positive cANCA confirmed the diagnosis of Wegener's granulomatosis. Dialysis was started, together with cyclophosphamide, corticosteroids and plasmapheresis, resulting in normalisation of renal function and symptomatic improvement of his heart failure. Contrast-enhanced cardiac MRI (panels B–D), performed 4 months after his initial presentation, showed continuing severe systolic dysfunction (EF = 29%) and multiple foci of delayed enhancement typical of myocardial necrosis and scarring.

The MRI findings are consistent with the sequelae of myocarditis or focal granulomatous necrosis, both of which are associated with Wegener's granulomatosis. The patient remains stable with NYHA class II symptoms and normal renal function.

**Andrew To, Janak De Zoysa, Jonathan P Christiansen**
Jonathan.Christiansen@WaitemataDHB.govt.nz




Light microscopy of the renal biopsy, showing typical crescent formation in a collapsed hypercellular glomerulus. Immunofluorescence was negative for immunoglobulins, consistent with a diagnosis of pauci-immune crescentic glomerulonephritis from Wegener's granulomatosis (panel A). Contrast-enhanced cardiac MRI—delayed enhancement images: (panel B) four-chamber view showing foci of mid-myocardial scarring in the interventricular septum (arrows); (panel C) mid-ventricular short axis image demonstrating both subendocardial and mid-myocardial scar (arrows); (panel D) three-chamber view showing partial thickness subendocardial scarring in the mid-inferolateral segment (arrows).

To view video footage demonstrating severe LV systolic dysfunction and multiple focal wall motion abnormalities, correlating with areas of delayed enhancement, visit the *Heart* website—http://heart.bmj.com/supplemental